



# IDAHO DEPARTMENT OF HEALTH & WELFARE

C. L. "BUTCH" OTTER, GOVERNOR  
RICHARD M. ARMSTRONG, DIRECTOR

DEBBY RANSOM, R.N., R.H.I.T. – Chief  
BUREAU OF FACILITY STANDARDS  
3232 Elder Street  
P.O. Box 83720  
Boise, Idaho 83720-0036  
PHONE: (208) 334-6626  
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December 9, 2009

Ferren Weeks  
Yellowstone Group Home #5 Burke  
560 West Sunnyside  
Idaho Falls, ID 83401

RE: Yellowstone Group Home #5 Burke, provider #13G067

Dear Mr. Weeks:

This is to advise you of the findings of the Medicaid/Licensure survey of Yellowstone Group Home #5 Burke, which was conducted on December 3, 2009.

Enclosed is a Statement of Deficiencies/Plan of Correction Form CMS-2567, listing Medicaid deficiencies and a similar form listing State licensure deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction. **It is important that your Plan of Correction address each deficiency in the following manner:**

1. Answer the deficiency statement, specifically indicating how the problem will be, or has been, corrected. Do not address the specific examples. Your plan must describe how you will ensure correction for all individuals potentially impacted by the deficient practice.
2. Identify the person or discipline responsible for monitoring the changes in the system to ensure compliance is achieved and maintained. This is to include how the monitoring will be done and at what frequency the person or discipline will do the monitoring.
3. Identify the date each deficiency has been, or will be, corrected.
4. Sign and date the form(s) in the space provided at the bottom of the first page.

5. Include dates when corrective action will be completed. 42 CFR 488.28 states ordinarily a provider is expected to take the steps needed to achieve compliance within 60 days of being notified of the deficiencies. Please keep this in mind when preparing your plan of correction. For corrective actions which require construction, competitive bidding, or other issues beyond the control of the facility, additional time may be granted.

Sign and date the form(s) in the space provided at the bottom of the first page.

After you have completed your Plan of Correction, return the original to this office by **December 22, 2009**, and keep a copy for your records.

You have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2007-02. Informational Letter #2007-02 can also be found on the Internet at:

<http://www.healthandwelfare.idaho.gov/site/3633/default.aspx>

This request must be received by December 22, 2009. If a request for informal dispute resolution is received after December 22, 2009, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during our visit. If you have questions, please call this office at (208) 334-6626.

Sincerely,



MONICA WILLIAMS  
Health Facility Surveyor  
Non-Long Term Care



NICOLE WISENOR  
Co-Supervisor  
Non-Long Term Care

MW/mlw

Enclosures

12/22/2009

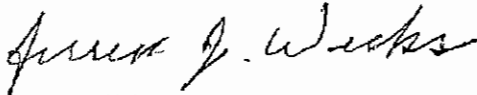
Monica Williams  
Health Facility Surveyor  
Non-Long Term Care

Bureau of Facility Standards  
3232 Elder Street  
P.O. Box 83720  
Boise, ID 83720-0036

Dear Ms. Williams,

Enclosed is the plan of correction for the Burke home survey. If I need to clarify anything please feel free to call me. I appreciate the professionalism and candor afforded by your team. As always it is a pleasure to have you visit us and to have the opportunity to work with you.

Sincerely,



Ferren J. Weeks NHA, QMRP  
Regional Administrator Yellowstone Group Homes

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/08/2009  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  13G067	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  12/03/2009
NAME OF PROVIDER OR SUPPLIER  YELLOWSTONE GROUP HOME #5 BURKE			STREET ADDRESS, CITY, STATE, ZIP CODE 4541 EAST BURKE DRIVE AMMON, ID 83406		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 000	INITIAL COMMENTS  The following deficiencies were cited during the annual recertification survey.  The survey was conducted by: Monica Williams, QMRP, Team Lead Amy Petersen, QMRP  Common abbreviations/symbols used in this report are: QMRP - Qualified Mental Retardation Professional	W 000			
W 455	483.470(l)(1) INFECTION CONTROL  There must be an active program for the prevention, control, and investigation of infection and communicable diseases.  This STANDARD is not met as evidenced by: Based on observation and staff interviews, it was determined the facility failed to ensure infection control procedures were followed to prevent and control infection and/or communicable diseases for 4 of 6 individuals (Individuals #2 - 5) residing in the facility. This had the potential to provide opportunities for cross-contamination to occur and negatively impact individuals' health. The findings include:  During an environmental review on 12/2/09 from 2:40 - 4:03 p.m., the following concerns were noted:  - It was noted there were rodent droppings in the silverware trays located in a drawer in the kitchen. The Shift Supervisor, who was present during the review, was immediately notified of the findings. The Shift Supervisor proceeded to remove the	W 455	Please see attached Plan of Correction <i>[Signature]</i>		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X5) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 455	<p>Continued From page 1</p> <p>silverware and trays in order to wash and sanitize them.</p> <p>- The hygiene kits belonging to Individuals #2 - #5 were observed to contain uncovered toothbrushes laying next to used electric razors and hairbrushes. The Shift Supervisor, who was present, stated the toothbrushes should have been covered. When asked, the QMRP stated during an interview on 12/3/09 from 9:02 - 9:50 a.m., the toothbrushes should have been kept in a separate bag or container.</p> <p>The facility failed to ensure measures were taken to prevent and control for rodents and Individuals #2 - 5's hygiene kits were maintained in a sanitary manner.</p>	W 455			

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MM269	15.03.11.100.04 Insect and Rodent Control  Insect and Rodent Control. The facility must be maintained free from insects, rodents and other pests. Chemicals (pesticides) used in the control program must be selected, used, and stored in the following manner:  This Rule is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to maintain areas to ensure they were free from rodents for 6 of 6 individuals (Individuals #1- #6) residing in the facility. This had the potential to negatively impact individuals' health. The findings include:  During an environmental review on 12/2/09 from 2:40 - 4:03 p.m., it was noted there were rodent droppings in the silverware trays located in a drawer in the kitchen.  The Shift Supervisor, who was present during the review, was immediately notified of the findings. The Shift Supervisor proceeded to remove the silverware and trays in order to wash and sanitize them.  The facility failed to ensure the facility was kept free from rodents.	MM269	Please refer to W 455 - fzu	
MM271	16.03.11.100.04(b) Storage of Toxic Chemicals  All toxic chemicals must be properly labeled and stored under lock and key. This Rule is not met as evidenced by: Based on observation and staff interviews, it was determined the facility failed to ensure all chemicals were properly labeled and toxic chemicals were stored under lock and key for 6 of 6 individuals (Individuals #1 - #6) residing in the facility. This resulted in the potential for	MM271	Please see attached Plan of Correction fzu	

Bureau of Facility Standards

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

5869

LJ2811

TITLE

Regional Admin

(X6) DATE

12/22/09

If continuation sheet 1 of 5

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MM271	<p>Continued From page 1</p> <p>misuse of chemicals and the potential for individuals having access to toxic chemicals. The findings include:</p> <p>During an environmental review on 12/2/09 from 2:40 - 4:03 p.m., the following chemicals were found to be unlocked and in either unmarked or mis-marked containers in the garage:</p> <ul style="list-style-type: none"> <li>- There were two red gasoline containers which contained gasoline that were not stored under lock and key. It was noted that there was a cigarette butt laying nearby.</li> <li>- There was one container of oil and gasoline that was not labeled, and it was not stored under lock and key. During the review, Individual #6 came into the garage. When asked, he stated the oil/gas mixture belonged to him.</li> <li>- There was a container of motor oil that was not stored under lock and key.</li> <li>- A laundry detergent container was labeled "fuel." The Maintenance Manager, who was present during the review, stated the contents of the container was water and it belonged to Individual #3.</li> </ul> <p>The Shift Supervisor and Maintenance Manager were notified of the unlocked and unmarked chemicals and proceeded to secure them under lock and key.</p> <p>The facility failed to ensure all chemicals were labeled and stored appropriately.</p>	MM271			
MM298	16.03.11.100.06(e) Storage Areas, Attics, Basements	MM298			

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If continuation sheet 2 of 5

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MM298	Continued From page 2  Storage areas, attics, basements, and grounds must be kept free from refuse, litter, weeds, or other items detrimental to the health, safety, or welfare of the residents. This Rule is not met as evidenced by: Based on observation and staff interviews, it was determined the facility failed to ensure grounds were kept free from items detrimental to the health, safety, and welfare for 6 of 6 individuals (individuals #1 - #6) residing in the facility. This resulted in trip hazards being present for individuals. The findings include:  During an environmental review on 12/2/09 from 2:40 - 4:03 p.m., the following concerns were noted.  - There were eight gopher holes in the back yard.  - There was a large sink hole, located over the septic system, in the back yard.  - There was trough in the back yard that ran from the side of the house to the fence line. The trough was approximately 9 inches wide, 8 inch deep, and 15 feet long.  The Maintenance Manager, who was present during the review, stated the trough was from a water line, the sink hole needed to be filled, and they (the facility) would address the gopher issue.	MM298	<i>Please see attached Plan of Corrections 12/2/09</i>		
MM380	16.03.11.120.03(a) Building and Equipment  The building and all equipment must be in good repair. The walls and floors must be of such character as to permit frequent cleaning. Walls and ceilings in kitchens, bathrooms, and utility rooms must have smooth enameled or equally washable surfaces. The building must be kept	MM380	<i>Please see attached Plan of Corrections 12/2/09</i>		

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If continuation sheet 3 of 5

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MM380	Continued From page 3  clean and sanitary, and every reasonable precaution must be taken to prevent the entrance of insects and rodents. This Rule is not met as evidenced by: Based on observation, it was determined the facility failed to ensure the facility was kept clean and in good repair, and every reasonable precaution was taken to prevent the entrance of insects for 6 of 6 individuals (Individuals #1 - #6) residing in the facility. This resulted in the environment being kept in ill-repair. The findings include:  During an environmental review on 12/2/09 from 2:40 - 4:03 p.m., the following concerns were noted:  Kitchen: - There were dried bread crumbs on the shelf under the toaster. - A large cookie sheet contained burned-on grease and rust. - The water tray on the refrigerator door contained a build-up of dust. - The oven contained burned-on food. - The oven drawer contained food debris. - There was mold in the dishwasher. - The foot plate on the refrigerator contained a build-up of debris and was loose from the refrigerator.  Living Room: - There were no screens on two of the living room windows.  Hall Bath: - The caulking was missing in front of the base of the toilet and bathtub.  Back Bath:	MM380			

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If continuation sheet 4 of 5

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## Bureau of Facility Standards

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MM380	Continued From page 4  - The caulking was loose around the base of the toilet. - The caulking was black and there were bits of it missing in front of the shower.  Garage: - The refrigerator in the garage contained food spills. - A wall in the garage was missing sheet rock resulting in: exposed insulation.	MM380			
MM769	16.03.11.270.03(c)(vi) Control of Communicable Diseases and Infectio  Control of communicable diseases and infections through identification, assessment, reporting to medical authorities and implementation of appropriate protective and preventative measures. This Rule is not met as evidenced by: Refer to W455.	MM769	Please refer to W455 A 2w		

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If continuation sheet 5 of 5

12/22/09

### Burke Survey Plan of Correction

#### W455 (mouse droppings)

Situation was immediately cleaned up and all Burke staff were counseled on proper cleaning techniques. Cleaning lists were modified to include greater detail of what was expected. When a follow up internal inspection revealed unsatisfactory progress the responsible staff was terminated. Responsible party is Nick Schmitt Home Admin.

#### W455 (hygiene kits)

New toothbrush holders and spares were purchased to ensure that this situation does not repeat itself. Responsible party is Nick Schmitt Home Admin.

#### MM269 (mouse droppings (see W455))

MM271 (chemical storage) All gas and motor oil was properly labeled and locked in the external shed behind the house to limit access. The cigarette butts belonged to the staff that no longer works here due to issues with W455, so that issue has been addressed as well. Responsible party is Nick Schmitt Home Admin.

#### MM298 (rodent holes)

An electronic rodent removal device that drives away rodents via the emittance of ultrasonic sounds undetectable to the human ear will be procured and installed at Burke by 1/30/2010. The thought is that will also assist with the issues observed in W455 and MM269. Responsible party is Nick Schmitt Home Admin to see that this is completed.

MM380

Kitchen- Cleaning list detail modifications and staff replacement ought to appropriately address limitations observed.

Living room - screens were replaced by maintenance.

Hall bath - caulking reapplied by maintenance.

Back bath - caulking reapplied by maintenance.

Garage - Fridge mess addressed via cleaning list modification and staff training.

Sheetrock will be replaced by maintenance by 1/30/2010

Responsible party is Nick Schmitt Home Admin to see that the cleaning logs accurately reflect the condition of the cleanness of the home through out and that all maintenance work is completed.

MM769

See W455

*James J. Wicks*  
*12/22/09*